IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER– Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

January 12, 2007

Charlene Humpherys, Administrator
Cedar Crest Residential Care
1200 E 6th South
Mountain Home, ID 83647

License #: RC-428

Dear Ms. Humpherys:

On October 4, 2006, a complaint investigation, state licensure survey was conducted at Cedar Crest Residential Care. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Patrick Hendrickson, RN, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

PATRICK HENDRICKSON, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

PH/slc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program

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October 16, 2006

CERTIFIED MAIL #: 7003 0500 0003 1967 1305

Charlene Humpherys, Administrator
Cedar Crest Residential Care
1200 E 6th South
Mountain Home, ID 83647

FILE COPY

Dear Ms. Humpherys:

Based on the state licensure survey conducted by our staff at Cedar Crest Residential Care on **October 4, 2006,** we have determined that the facility failed to protect residents from abuse. Based on observation, interview, and record review, it was determined the facility failed to implement policies and procedures to protect 2 of 10 sampled residents (#3 and #9) and potentially 100% of the female residents in the facility from sexual abuse when an allegation of abuse was reported.

Based on interview and record review, it was also determined the facility failed to develop and implement BMP's for 2 of 10 sampled residents reviewed (#4 and #5).

These core issue deficiencies substantially limit the capacity of Cedar Crest Residential Care to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **November 11, 2006. We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **October 29, 2006,** and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**October 29, 2006**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **October 29, 2006,** your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **November 4, 2006**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Cedar Crest Residential Care.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

Patty West-Heir for

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/slc

Enclosure

c: Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Marilyn Kelseth, RN, Program Manager, Regional Medicaid Services, Region IV - DHW

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
KARL B. KURTZ – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
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PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL 7003 0500 0003 1967 1305

October 16, 2006

Charlene Humphreys, Administrator
Cedar Crest Residential Care
1200 East 6th South
Mountain Home, ID 83647

FILE COPY

Re: Enforcement Action – Cedar Crest Residential Care

Dear Ms. Humphreys:

As a result of the complaint investigation, state licensure survey conducted on October 4, 2006, Cedar Crest Residential Care was issued core issue deficiencies for failing to protect residents from abuse for 2 of 10 sampled residents and for failing to develop and implement behavior management plans for 2 of 10 sampled residents. These core issues substantially limit the capacity of Cedar Crest Residential Care to ensure that residents' health and safety are safe-guarded. The deficiencies are described on the enclosed Statement of Deficiencies.

Due to the seriousness of these core issues and in accordance with IDAPA 16.03.22.900.04 the following enforcement actions are imposed:

1. **The facility will correct the deficient area in accordance with the submitted Plan of Correction no later than November 11, 2006;**
2. **A registered nurse consultant, with a background in residential care and/or long term care, will be obtained and paid for by the facility, and approved by the Department. This registered nurse consultant may not also be employed by the facility as a regular employee. The registered nurse consultant is to be allowed unlimited access to the facility and its systems for the provision of care to residents. The name of the consultant with the person's qualifications will be submitted to the Department for approval no later than October 30, 2006;**
3. **The Department approved consultant will submit a weekly written report to the Department commencing on November 6, 2006 and every Friday thereafter. The reports will address progress on correcting the deficiencies on the Statements of Deficiencies and Non-Core Issues Punch Lists.**

4. **The facility will maintain, on an ongoing basis, the deficient area in a state of compliance in accordance with the submitted Plan of Correction;**

5. **When the consultant and the administrator agree the facility is in full compliance, they will notify the Department and a follow-up survey will be conducted.**

Please be advised that you may contest this decision by filing a written request for administrative review pursuant to IDAPA 16.05.03.300. **no later than twenty-eight (28) days after this notice was mailed.** Any such request should be addressed to:

Randy May
Deputy Administrator
Division of Medicaid-DHW
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036

If you fail to file a request for administrative review within the time allowed, this decision shall become final.

Staff from the Residential Community Care Program is available to help avoid additional negative actions. Should you desire technical assistance, please contact this office at (208) 334-6626.

Sincerely,

Patty Watt-Levier for

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

Enclosure

c: Sharon Duncan, Chief, Bureau of Long Term Care and State Operations
Marilyn Kelseth, Regional Manager Long Term Care Services Region IV
Debra Ransom, R.N., R.H.I.T., Chief, Bureau of Facility Standards
Randy May, Deputy Administrator, Division of Medicaid
Willard Abbott, Deputy Attorney General, Human Service Division

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13R428	A. BUILDING _____ B. WING _____	10/04/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR CREST RESIDENTIAL CARE	1200 E 6TH SOUTH MOUNTAIN HOME, ID 83647

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	Initial Comments The following deficiency was cited during the standard survey and complaint investigation conducted at your residential care/assisted living facility on October 4, 2006. The surveyors conducting your survey were: Rae Jean McPhillips, RN, BSN Team Coordinator Health Facility Surveyor Polly Watt-Geier, LMSW Health Facility Surveyor John Wingate, RN Health Facility Surveyor Debbie Sholley, LSW Health Facility Surveyor Survey Definitions: UAI = Uniform Assessment Instrument NSA = Negotiated Service Agreement BMP = Behavior Management Plan	R 000		
R 006	16.03.22.510 Protect Residents from Abuse. The administrator must assure that policies and procedures are implemented to assure that all residents are free from abuse. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to implement policies and procedures to protect 2 of 10 sampled residents (#3 and #9) and potentially 100% of the female residents in the facility from sexual abuse when an allegation of abuse was	R 006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 006	Continued From page 1 reported. The findings include: 1. Document titled "Policy on Abuse" (undated) states "It shall be the policy of Cedar Crest Residential Care Center that any and all abuse shall be reported to the administrator. An incident report shall be written and an investigation shall be made." Review of Resident #4's record on 10/2/06 revealed the resident was admitted on 9/17/04 with diagnoses which included developmentally delayed, deafness and schizophrenia. Resident #4's UAI, dated 8/28/06, documented under section "Assaultive/Destructive Behavior" the resident was sometimes assaultive and required special tolerance and management. Additionally, under the section "Disruptive/Socially Inappropriate Behavior" it documented the resident was frequently disruptive, aggressive or socially inappropriate. Review of Resident #4's record revealed a note written by the administrator on 9/30/06. The note documented that the administrator received a report that Resident #4 had touched Resident #3's breast. Review of Resident #3's record on 10/2/06 revealed the resident was admitted on 8/27/05 with diagnosis which included Alzheimer's. Review of Resident #3's record revealed an UAI dated 8/27/06. It documented the resident needed total assistance with 24 hour supervision. Under the section "Self-Preservation or Victimization" it documented the resident needed protection. Additionally, the UAI documented the resident was not orientated to	R 006		

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R 006	Continued From page 2 time and place, had poor memory, and poor judgement. Resident #3's record also contained an NSA dated 8/27/06. The NSA documented the resident needed 24 hour supervision. On 10/2/06 at 11:58 a.m., Resident #3 was observed sitting in the common area in her wheelchair. She was observed speaking incoherently and was unable to form understandable words or sentences. On 10/3/06 at 10:48 a.m., a caregiver stated "I haven't witnessed anything but all the other caregivers know about and have told me of at least two different incidents in which Resident #4 has done things like grabbing the breasts and other things to Resident #3 and Resident #9." The caregiver further stated "I'm pretty sure the administrator knows about it, she should, this has been going on for a long time." On 10/3/06 at 11:01 a.m., Resident #9 stated Resident #4 had fondled Resident #3 in the common sitting area. She stated Resident #3 would pull away, but was not able to stop Resident #4 from touching her inappropriately due to her physical and mental condition. During an interview on 10/3/06 at 12:02 p.m., Resident #4 wrote a confirmation statement that he was sorry he "touched women's bodies in their bedrooms." He further verbalized that he wore a robe into the rooms and was naked underneath. On 10/3/06 at 12:46 p.m., the administrator stated that she had been told by a caregiver that Resident #4 had groped Resident #3 in the common area of the facility. Additionally, she	R 006		

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R 006	Continued From page 3 stated she had not investigated the allegation of inappropriate behaviors by Resident #4 because the caregiver who had told her was not available. 2. Review of Resident #9's record on 10/3/06 revealed the resident was admitted on 6/11/06 with diagnoses which included congestive heart failure and Alzheimer's. Further review of the resident's record revealed an NSA dated 6/21/06. The NSA documented the resident was unable to discern situations where she could be abused or neglected. On 10/3/06 at 10:48 a.m., a caregiver stated Resident #4 had touched Resident #9 inappropriately. On 10/3/06 at 11:01 a.m., the resident stated Resident #4 had touched her inappropriately approximately 2 to 3 weeks ago around 7:30 a.m. She stated Resident #4 walked into her room, woke her up and was wearing a robe a long robe that was down to his ankles. She stated he disrobed and was naked. She also stated the resident made her sit on the edge of the bed and he placed his penis in her mouth and ejaculated. She stated she felt sick and had to focus so she wouldn't throw-up. She stated that after he had finished he left her room. Additionally, she stated Resident #4 lived two doors down from her and he sat at the same dining room table as she did during meals. She stated she had ignored him since the incident occurred. On 10/3/06 at 12:02 p.m., Resident #4 confirmed he had "touched women's bodies in their bedrooms". Additionally, he verbalized that he wore a robe into the rooms and was naked underneath.	R 006		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 006	Continued From page 4 On 10/3/06 at 12:36 p.m., a police officer confirmed Resident #9's statement matched Resident #4's statement. On 10/4/06 at 9:38 a.m., the administrator stated Resident #9 had recently declined and had not been eating. She stated she had not known Resident #9 had been sexually assaulted prior to the investigation by the licensing agency, adult protection, and the police. She stated after she had talked with Resident #9 she believed the allegation had happened. The facility failed to complete an incident report and initiate an investigation as described in their policies. Further, the facility failed to protect Resident #3, Resident #9 and potentially 100% of the female residents in the facility from sexual abuse. The facility was required to submit an immediate plan of correction to assure residents were protected from sexual abuse. Additionally, the facility was required to submit a plan of correction to ensure compliance in implementing the facility's policy and procedures on abuse.	R 006		
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on interview and record review it was determined the facility failed to develop and implement BMP's for 2 of 10 sampled residents reviewed, (#4 and #5).	R 008		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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R 008	Continued From page 5 1. Review of Resident #4's record on 10/3/06 revealed that the resident was admitted on 9/17/04 with diagnoses which included developmental disability, deafness and schizophrenia. Review of resident #4's record revealed a UAI dated 8/28/06. The UAI section "Disruptive/Socially Inappropriate Behavior" documented the resident was frequently disruptive/aggressive, socially inappropriate, agitated, or anxious. May require professional consultation for behavioral management program. Further review of UAI under section "Assaultive/Destructive Behavior" documented the resident was, at times assaultive. Review of Resident #4's record revealed an NSA dated 9/10/06 which revealed there was no documentation of behaviors or of a BMP. The Incidents/Accidents log documented that on 5/28/06 Resident #4 became agitated and upset with staff and smashed a ceramic coffee cup on the medication room door. On 10/3/06 at 10:48 a.m., a caregiver stated "Resident #4 has become angry and aggressive with staff, other residents and has smashed things in the past." She also said he has been sexually inappropriate with female residents. On 10/3/06 at 11:01 a.m., Resident #9 stated Resident #4 had fondled Resident #3 in the common sitting area. She stated Resident #3 would pull away, but was not able to stop Resident #4 from touching her inappropriately due to her physical and mental condition. On 10/3/06 at 10:40 a.m., the administrator	R 008		

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R 008	Continued From page 6 confirmed that Resident #4 did not have a BMP. 2. Review of Resident #5's record on 10/2/06, revealed the resident was admitted on 10/2/02 with diagnosis which included schizophrenic affective disorder. Further review of the resident's record revealed an NSA dated 1/6/06. The NSA documented the resident displayed aggressive behaviors in the community, called in false alarms to the fire department and set off fire alarms. There was no documented evidence of a BMP. On 10/3/06 at 1:20 p.m., the administrator stated Resident #5 hid the fire extinguishers, set off the fire alarms, and called in false reports to the fire department. Additionally, the administrator confirmed she had not developed a BMP to address Resident #5's inappropriate behaviors. The facility failed to update the NSA's to include BMP's for Resident #4 and 5's inappropriate behaviors. As the NSA was not complete the facility could not implement an NSA that provided guidance to personnel in their provision of care and services to meet the needs of the resident.	R 008		

Plan of Correction for Cedar Crest Residential Care

1. IDAPA 16.03.22.510 Protect Residents from Abuse:

    a. The corrective action for the identified residents include: Resident #4 was immediately discharged from the facility.

    Resident #3 and #9 will be offered counseling for the inappropriate behaviors of Resident #4. They will be monitored for signs and symptoms of abuse. And an incident report will be filled out with the administrator's investigation of the incident.

    b. All of the current and perspective male residents will be assessed/re-assessed. Their histories and physicals, and UAI's, will be reviewed for inappropriate behaviors. If inappropriate behaviors are identified the residents will be assessed to determine if they are appropriate to remain in the facility or be admitted into the facility.

    c. All prospective residents' UAI's and histories and physicals will be reviewed by the facility's RN and administrator. The sexual offender site will be reviewed to ensure prospective residents are not on the list.

    Staff will be in-serviced on whom to report suspected abuse. Staff will re-read the facility's policy and procedure for abuse. The number for Adult Protection, Ombudsman, and local Police Department will be available in the facility for facility staff. Staff will also be in-serviced on when to fill out incident reports.

    d. The facility's administrator will monitor residents' behaviors on a daily basis and notify the RN. The RN will monitor the residents' behaviors every 90 days or when there is a change in residents' condition.

    e. The administrator and consultant will notify the department when the corrective actions have been completed per the letter, from the Department, to the facility dated October 16, 2006.

2. IDAPA 16.03.22.520 Protect Residents from Inadequate Care:

    a. Resident #4 was immediately discharged from the facility. Resident #5's UAI and history and physical will be reviewed and a behavior management plan and tracking form will be implemented.

    b. All current residents' UAI's and histories and physicals will be reviewed. If any of the current residents have inappropriate behaviors, behavior management plans and tracking forms will be implemented. Prospective

residents' will be assessed, histories and physicals, any other documentation will be reviewed. If the resident is found to have inappropriate behaviors, behavior management plans and tracking forms will be implemented.

c. Staff will be in-serviced on documentation of behaviors and whom to report behaviors to. Staff will be in-serviced and required to re-read the facility's policy and procedure for behavior management.

   Behavior management plans will be developed and tracking forms will be in place when residents exhibit inappropriate behaviors.

d. The administrator will monitor residents' inappropriate behaviors on a daily basis and report them to the facility's RN. The facility's RN will monitor residents' behaviors every 90 days or when there is a change in condition.

e. The administrator and consultant will notify the department when the corrective actions have been completed per the letter, from the Department, to the facility dated October 16, 2006.

Charlene Dunphrey Adm.

POC ovd 12/11/06

Punch list deficiencies for Cedar Crest Residential Care

1. The facility developed new activities calendars according to what residents wanted. See attached copy (#1)
2. The facility's RN assessed the identified residents and is in the process of assessing the remaining facility residents. See attached copies labeled #2.
3. The facility's RN delegated assistance with medications to all staff that are certified to assist with medications. See attached copies labeled #3.
4. The facility personnel had an in-service on whom to report inappropriate sexual behaviors. There have been no other incidents at this time that require reporting to the appropriate agencies. See attached copy of the in-service labeled #4.
5. Facility personnel received an in-service regarding documentation to include the reason for missed medications, medications not given, refused medications and as needed medications. The attached document is what is being used at this time for documenting medications that were missed, refused, not given and as needed, until the new computer system is implemented. See attached copies labeled #5.
6. The personnel who were identified as needing criminal background checks went on line and submitted the self declaration form and printed it off. All staff who were hired after 10-1-05 has submitted the self declaration form and have made appointments to get fingerprinted. The results will be in their personnel files as soon as they have been done. One of the personnel identified as needing a criminal background check no longer works at the facility. (Olga Peterson). The online printed self declaration forms for the identified personnel are labeled #6.

IDAHO DEPARTMENT OF
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October 27, 2006

Charlene Humpherys, Administrator
Cedar Crest Residential Care
1200 E 6th South
Mountain Home, ID 83647

Dear Ms. Humpherys:

On October 4, 2006, a complaint investigation survey was conducted at Cedar Crest Residential Care. The survey was conducted by John Wingate, R.N., Polly Watt-Geier, LSW, Rae Jean McPhillips, R.N., and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00001774

Allegation #1: The facility did not assist identified residents with medications as prescribed by the physician or authorized provider.

Findings: Based on observation, interview and record review it was determined the identified residents were assisted with medications as ordered by a physician or authorized provider.

Review of the identified residents' records revealed medications were given as ordered by a physician or authorized provider.

On October 2, 2006 at 12:00 p.m., 5 residents were observed to be assisted with their medications as ordered by a physician or authorized provider.

On October 2, 2006 and October 3, 2006 the identified residents stated they had no complaints about not getting thier medications as ordered by their physician or authorized provider.

On October 2, 2006 at 11:55 a.m., the administrator denied the identified residents did not receive thier medications as ordered by a physician or authorized provider.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the

complaint investigation conducted on October 4, 2006.

Allegation #2: The facility does not document medications that were taken, refused, missed, not taken, or not given.

Findings: Based on interview and record review it was determined the facility did not document medications that were taken, refused, missed, not taken, or not given.

Review of the facility's September 2006 medication assistance record (MAR), revealed medications that were taken, refused, missed, not taken, or not given were not consistently documented.

On October 2, 2006 at 9:14 a.m., the administrator confirmed not all medications were documented when they were taken, refused, missed, not taken, or not given to residents.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.711.11 for not documenting when medications were taken, refused, missed, not taken, or not given to residents. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The facility did not have Negotiated Service Agreements (NSA's) that assessed the identified residents behavioral needs.

Findings: Based on interview and record review it was determined the facility did not have NSA's that assessed the identified residents behavioral needs.

Review of an identified resident's record revealed a uniform assessment instrument (UAI) dated August 28, 2006. The UAI section "Disruptive/Socially Inappropriate Behavior" documented the resident was frequently disruptive/aggressive, socially inappropriate, agitated, or anxious. May require professional consultation for behavioral management program. Under the section "Assaultive/Destructive Behavior" documented the resident was, at times assaultive.

The record contained a NSA dated September 10, 2006 which did not document behaviors or a behavior management plan (BMP).

Review of the Incidents/Accidents log documented that on May 28, 2006 the identified resident became agitated and upset with staff and smashed a ceramic coffee cup on the medication room door.

On October 3, 2006 at 10:48 a.m., a caregiver stated the identified male resident had become angry and aggressive with staff, other residents and had smashed things in the past. She also said he had been sexually inappropriate with female residents.

On October 3, 2006 at 11:01 a.m., a random resident stated the identified male resident had fondled an identified female resident in the common sitting area.

On October 3, 2006 at 10:40 a.m., the administrator confirmed the identified resident did not have a BMP.

Review of a second identified resident's record revealed an NSA dated January 6, 2006. The NSA documented the resident displayed aggressive behaviors in the community, called in false alarms to the fire department and set off fire alarms. There was no documented evidence of a BMP.

On October 3, 2006 at 1:20 p.m., the administrator stated the identified resident hid the fire extinguishers, set off the fire alarms, and called in false reports to the fire department. Additionally, the administrator confirmed she had not developed a BMP to address the resident's inappropriate behaviors.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.520 for failing to update the NSA's to include BMP's for the identified residents inappropriate behaviors. As the NSA's were not complete the facility could not implement an NSA that provided guidance to personnel in their provision of care and services to meet the needs of the resident. The facility was required to submit a plan of correction.

Based on the findings of the complaint investigation, the facility was found to be out of compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. A Statement of Deficiencies has been issued to your facility. Please develop a Plan of Correction as outlined in the cover letter to the Statement of Deficiencies. AND/OR Non-core issues were identified and included on the Punch List.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

RAE JEAN MCPHILLIPS, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

RM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
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November 13, 2006

FILE COPY

Charlene Humpherys, Administrator
Cedar Crest Residential Care
1200 E 6th South
Mountain Home, ID 83647

Dear Ms. Humpherys:

On October 4, 2006, a complaint investigation survey was conducted at Cedar Crest Residential Care. The survey was conducted by John Wingate, R.N., Polly Watt-Geier, LSW, Rae Jean McPhillips, R.N., and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00001840

Allegation #1: A resident had infected pressure sores that were not healing.

Findings: Based on interview and record review it was determined the resident did have one pressure sore that was healing and was not infected.

On October 3, 2006 review offacility records revealed documentation, dated April 21, 2006, that the identified resident did have a sore on her left hip. The record also provided documentation, dated April 27, 2006, that the sore had healed.

Home Health records for August 2006, reviewed on October 3, 2006, documented the resident had received wound care for a stage 2 pressure ulcer located on the left buttock. The Home Health records documented the wound was slowly healing and showed no signs of infection.

On October 3, 2006 at 3:00 p.m., the administrator stated the resident did have a small sore on her left buttock but was receiving wound care from Home Health. She stated the pressure sore was healing and did not have an infection.

Conclusion: Unsubstantiated. The identified resident did have a stage 2 pressure ulcer that was

healing and did not show signs or symptoms of infection.

Allegation #2: The resident eats poorly and needs to be fed, but they do not feed her.

Findings: Based on interview and record review it was determined that the resident did have difficulty feeding herself but there was no documentation that the resident was not fed.

The identified resident's negotiated service agreement (NSA), dated March 7, 2006, reviewed on October 3, 2006 documented the identified resident could put finger foods in her mouth but was unable to use utensils because of tremors and that staff were to assist her with eating.

On October 3, 2006 at 2:00 p.m., the administrator stated the resident required total assistance with eating. She could use her fingers to put small, cut up portions of food in her mouth but staff did most of the feeding. She stated they were giving her supplemental nutritional drinks and offered her frequent snacks to ensure she received enough nutrition.

On October 3, 2006 at 3:15 p.m., a caregiver stated they would cut up the resident's food into small portions that she could pick up and eat if she wanted. She said that some days the resident did not want to feed herself and that staff would assist her with eating. Additionally, she stated they offered the resident frequent snacks.

Conclusion: Unsubstantiated. The facility acted appropriately by providing the resident with assistance in eating, offering frequent snacks and giving her supplemental nutritional drinks.

Allegation #3: The identified resident could not move, but would merely sit all day in his wheelchair and had a table in front of him.

Findings: Based on observation, interview and record review it was determined the identified resident was able to move and did not sit all day in his wheelchair with a table in front of him.

The identified resident's record contained an NSA dated November 12, 2006, which documented the resident was able to navigate his wheelchair and move around the facility independently.

On October 3, 2006 at 11:45 a.m., the resident was observed sitting in the common room with other residents. A caregiver was observed moving the resident away from a table after the meal was completed.

On October 4, 2006 at 9:11 a.m., the resident was observed sitting in the common room with other residents. He did not have a table in front of him.

On October 4, 2006 at 9:15 a.m., the administrator stated the resident was able to move away from sitting at the table.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 4, 2006.

Allegation #4: On 9/3/06 a resident "vomited feces" and the caregivers sent the resident to the emergency room.

Findings: Based on interview and record review it was determined the resident did become ill and was taken to the emergency room.

Review of the facility's "Nurse Communication Log" dated September 4, 2006 revealed the resident was transported by emergency transport to the emergency room after he vomited at the facility.

On October 4, 2006 at 9:14 a.m., the administrator stated the caregivers have been instructed to immediately call for emergency services when a resident becomes ill. She stated the resident was transported to the emergency room, then the caregivers notified her of the transport. She also stated she notified the nurse about the resident had been transported to the hospital.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by calling emergency services when a resident became ill and needed a medical evaluation.

Allegation #5: The identified resident was left unsupervised while at a medical appointment on June 19, 2006. The resident was found the next day by the police. The resident was hungry and dehydrated.

Findings: Based on interview and record review it was determined the identified resident was left unsupervised while at a medical appointment.

Review of the identified resident's record on October 3, 2006 revealed a uniform assessment instrument (UAI) dated January 6, 2006, that documented the resident required minimal supervision with occasional voice cues and prompts.

Review of the facility's daily log notes revealed an entry, dated April 25, 2006, that documented the administrator asked the identified resident to wait in the lobby of the doctor's office while she went and got the car. When she brought the car back the

resident was gone. Additionally, it was documented the administrator called the police, searched the grounds of the doctor's office and went to the local homeless shelter to look for the resident.

On October 3, 2006 at 1:30 p.m., the administrator stated that after she called the police and searched the grounds of the doctor's office she went back to the facility and waited. She stated the police called her later that night or early the next morning and informed her they had found the identified resident. She stated at that time, she picked the resident up at a local restaurant.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by contacting the police to report the resident's absence.

Allegation #6: The identified resident was not supervised when he was left at the hospital on June 29, 2006 for appointments.

Findings: Based on interview and record review it was determined the identified resident was left at the hospital by the administrator.

Review of the resident's uniform assessment instrument (UAI), dated July 17, 2006, documented the resident needed minimal supervision.

The record contained a negotiated service agreement (NSA), dated and signed July 27, 2006 that stated the resident needed minimal supervision.

On October 3, 2006 at 11:00 a.m., the resident stated he was sent to the hospital by an immediate care clinic for an X-ray of his head to rule out a possible head injury from a fall the previous day. He said the administrator told him she would pick him up after he was done at the emergency room. He stated he was there until 10:00 p.m., when the hospital security guards called the administrator to come and pick him up. He said she told him that she had assumed he had been admitted to the hospital since he had not called her to pick him up.

On October 3, 2006 at 2:50 p.m., the administrator stated the arrangement with the resident was that he would call her when he was done at the emergency room. When the resident did not call her, she assumed the resident had been admitted to the hospital. She stated she immediately drove to the hospital to pick up the resident when she was called.

Conclusion: Substantiated. However, the facility was not cited as the administrator and the resident had made an arrangement that the administrator would be notified when she needed to pick the resident up from the hospital.

Allegation #7: An identified resident was not supervised when she went out shopping on July 29, 2006. The administrator did not pick her up when the administrator said she would.

Findings: Based on interview and record review it was determined the resident was allowed to shop independently and did not meet the administrator at the agreed upon time.

Review of the identified resident's record revealed a uniform assessment instrument (UAI) dated January 6, 2006. It documented the resident needed minimal supervision. It also documented the resident did her own shopping.

The resident's record contained a NSA dated January 15, 2006, which documented the resident shopped on her own.

On October 2, 2006 at 10:58 a.m., the resident stated the administrator had taken her to town to go shopping. She stated they had agreed upon a time to meet after she had finished shopping. She stated she was "window shopping' and decided to walk down to another store. She stated when she was at the other store she realized she had missed the agreed upon time to meet. She stated she was in the store when police arrived and was told the storekeeper had been concerned about her being at the store later than normal.

On October 4, 2006 at 9:14 a.m., the administrator stated the resident had been dropped off to shop and did not return at the agreed upon time. She was called by the police to notify her the identified resident had gone to another store. The administrator also stated when she was notified she went and picked up the resident at the store. She stated the resident's shopping had been reduced because of the incident. She now accompanied the resident shopping and limited the shopping to an hour.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by changing the resident's shopping routine to ensure that she would not be left at a store.

Based on the findings of the complaint investigation, the facility was found to be out of compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. A Statement of Deficiencies has been issued to your facility. Please develop a Plan of Correction as outlined in the cover letter to the Statement of Deficiencies. AND/OR Non-core issues were identified and included on the Punch List.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

RAE JEAN MCPHILLIPS, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

RM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

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October 27, 2006

Charlene Humpherys, Administrator
Cedar Crest Residential Care
1200 E 6th South
Mountain Home, ID 83647

Dear Ms. Humpherys:

On October 4, 2006, a complaint investigation survey was conducted at Cedar Crest Residential Care. The survey was conducted by John Wingate, R.N., Polly Watt-Geier, LSW, Rae Jean McPhillips, R.N., and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00001841

Allegation #1: A resident had bed sores with her bones showing and had pus in them.

Findings: Based on interview and record review it was determined the identified resident did have have a pressure sore. There is no documented evidence that the pressure sore was infected or that the resident's bones were showing.

On October 3, 2006 facility records revealed documentation, dated April 21, 2006, that the identified resident did have a pressure sore on her left hip. The record also provided documentation, dated April 27, 2006, that the pressure sore had healed.

Home Health records, reviewed on October 3,2006, documented the resident received wound care for a stage 2 pressure ulcer located on her left, medial buttock. The Home Health records documented the wound was slowly healing and showed no signs of infection.

On October 3, 2006 at 3:00 p.m., the administrator stated the resident did have a small pressure sore on her left buttock but was receiving wound care from Home Health. She said caregivers encouraged the resident to move frequently but she resisted position change. Additionally, staff repositioned the resident every two hours

during the day and at night. She stated they offered the resident fluids, snacks and supplemental drinks to increase her nutritional intake to reduce her susceptibility to skin breakdown.

Conclusion: Substantiated. However, the facility was not cited as they acted appropriately by repositioning the resident frequently, engaging Home Health to provide wound care and trying to increase the resident's nutritional status to prevent skin breakdown.

Allegation #2: The facility prepared unrecognizable food.

Findings: Based on observation and interview it was determined the facility prepared recognizable food.

On October 2, 2006 at 12:15 p.m., the facility's lunch was observed to include meat loaf, bread, potatoes, and peas. An alternative of hamburger was observed to be available to a resident who requested the alternate meat choice.

Review of the facility's October 2006 menu documented the facility was to serve meat loaf, bread, potatoes, and peas for the main entree. The menu was signed and dated by a registered dietitian.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 4, 2006.

Allegation #3: The facility's administrator refused to serve an identified resident meals.

Findings: Based on interview it could not be determined the administrator refused to serve an identified resident meals.

On October 3, 2006 at 10:00 a.m., the identified resident stated that although the facility would occasionally serve foods that he could not eat they did not refuse to serve him. He stated the facility would offer soup or other alternatives but he frequently refused them because they did not sound good to him.

On October 4, 2006 at 9:40 a.m., the administrator stated she had never refused to serve meals to the identified resident. She said that they tried to work around his religious preferences and would offer him alternatives, but he frequently refused them.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 4, 2006.

Allegation #4: The facility does not have enough staff at night to meet the needs of the residents.

Findings: Based on interview and record review it was determined the facility had enough caregivers at night to meet the needs of the residents.

Review of the facility staffing schedule on October 3, 2006 revealed there were 3 caregivers from 10 p.m. to 6 a.m., to provide personal care services to the residents.

On October 2, 2006 between 10:40 a.m. and 11:37 a.m., 21 residents were interviewed and stated their care needs were being met by the facility caregivers.

On October 4, 2006 at 9:15 a.m., the administrator stated she was not aware of a time when the needs of the residents were not being met by the caregivers at the facility.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 4, 2006.

Allegation #5: Residents are not clean, they have feces under their nails.

Findings: Based on observation and interview it was determined residents were clean and did not have feces under their nails.

On October 2, 2006 between 10:40 a.m. and 11:37 a.m., during a tour of the facility, the residents appeared to be clean and well kept, none were noted to have feces under their nails.

On October 2, 2006 between 10:40 a.m. and 11:37 a.m., 21 residents were interviewed and stated they received their showers weekly and had no complaints about not receiving their showers.

On October 4, 2006 at 9:16 a.m., the administrator stated residents received showers twice a week by the caregivers. Additionally, she stated she was not aware of a time when residents were not clean or when they had feces under their nails.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 4, 2006.

Allegation #6: The residents have few activities and they sit around all the time.

Findings: Based on observation, interview and record review it was determined the facility did not offer activities and residents did sit around all day.

On October 2, 2006 at 10:45 a.m., 7 residents were observed sitting in rocking chairs in the common room.

On October 2, 2006 at 2:58 p.m., 7 residents were observed sitting in rocking chairs in the common room.

On October 2, 2006 at 3:42 p.m., 7 residents were observed sitting in rocking chairs in the common room.

During the survey conducted from October 2, 2006 to October 4, 2006, there were no activities observed at the facility.

Review of the facility's monthly activity calender on October 2, 2006 revealed Bingo was played on Saturday's at 2:00 p.m., and on the third Wednesday of the month. It also documented resident's had access to church services on Friday's and Sunday's.

On October 4, 2006 between 9:00 a.m. and 9:32 a.m., 8 residents were interviewed and had concerns that there were not enough activities for them at the facility.

On October 4, 2006 at 9:48 a.m., the administrator stated the residents had Bingo on Saturday's, but there were currently no exercise programs or further activities during the week.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.210 for not offering a variety of activities to residents. The facility was required to submit evidence of resolution within 30 days.

Allegation #7: An identified male resident touched an identified female resident inappropriately.

Findings: Based on observation, interview and record review it was determined a male resident did touch a female resident inappropriately.

Review of the identified resident's record revealed a note written by the administrator on September 30, 2006. The note documented that the administrator recieved a report that the identified resident had touched Resident #3's breast.

On October 3, 2006 at 10:48 a.m., a caregiver stated the identified resident had become angry and aggressive with staff, other residents and had smashed things in the past. She also said he had been sexually inappropriate with female residents.

On October 3, 2006 at 11:01 a.m., an identified resident stated the identified male resident had inappropriatelyy touched the identified female resident in the common sitting area.

During an interview on October 3, 2006 at 12:02 p.m., the identified male resident

wrote a confirmation statement that he was sorry he "touched womans bodies in their bedrooms." He further verbalized that he wore a robe into the rooms and was naked underneath.

On October 3, 2006 at 12:46 p.m., the administrator stated that she had been told by a caregiver on 9/30/06 that the identified male resident had groped a female resident in the common area of the facility. Additionally, she stated she had not investigated the allegation of inappropriate behaviors by the identified male resident because the caregiver who had told her was not available.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.510 for failure to complete an incident report and initiate an investigation as described in their policies. Further, the facility failed to protect residents in the facility from sexual abuse. The facility was required to submit an immediate plan of correction to protect the residents and additionally submit a plan of correction to ensure compliance in implementing the facility's policy and procedures on abuse.

Allegation #8: The identified residents are not receiving medications as ordered by the physician or authorized provider.

Findings: Based on interview and record review it could not be determined the identified residents did not receive their medications as ordered by a physician or authorized provider.

Review of the identified residents' records revealed medications were given as ordered by a physician or authorized provider.

On October 2, 2006 and October 3, 2006 the identified residents stated they had no complaints about not getting thier medications as ordered by their physician or authorized provider.

On October 2, 2006 at 11:55 a.m., the administrator denied the identified residents did not receive thier medications as ordered by a physician or authorized provider.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 4, 2006.

Allegation #9: The residents are overmedicated.

Findings: Based on interview and record review it was determined the facility was not overmedicating residents.

Review of identified residents records between October 2, 2006 and October 4, 2006

revealed no documented evidence of residents being overmedicated.

During the survey conducted between October 2, 2006 and October 4, 2006 residents were not observed to be overmedicated.

On October 2, 2006 between 10:40 a.m. and 11:37 a.m., 21 residents were interviewed and stated they did not feel that they were being overmedicated.

On October 2, 2006 at 11:55 a.m., the administrator stated she could not recall an incident that any residents had been overmedicated.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 4, 2006.

Based on the findings of the complaint investigation, the facility was found to be out of compliance with the rules for Residential Care or Assisted Living Facilities in Idaho. A Statement of Deficiencies has been issued to your facility. Please develop a Plan of Correction as outlined in the cover letter to the Statement of Deficiencies. AND/OR Non-core issues were identified and included on the Punch List.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

RN
for Rae Jean McPhillips.

RAE JEAN MCPHILLIPS, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

RM/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

IDAHO DEPARTMENT OF
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October 27, 2006

Charlene Humpherys, Administrator
Cedar Crest Residential Care
1200 E 6th South
Mountain Home, ID 83647

Dear Ms. Humpherys:

On October 4, 2006, a complaint investigation survey was conducted at Cedar Crest Residential Care. The survey was conducted by John Wingate, R.N., Polly Watt-Geier, LSW, Rae Jean McPhillips, R.N., and Debra Sholley, Social LSW. This report outlines the findings of our investigation.

Complaint # ID00001910

Allegation #1: The facility does not have enough caregivers to provide services to the residents.

Findings: Based on interview and record review it was determined the facility had enough caregivers to provide services to the residents.

Review of the facility staffing schedule on October 3, 2006 revealed there were 5 caregivers working from 6:00 a.m. to 2:00 p.m., 1 caregiver working from 10:00 a.m. to 4:00 p.m., 4 caregivers working from 2:00 p.m. to 10:00 p.m., and 3 caregivers working from 10 p.m. to 6 a.m., to provide personal care services to the residents.

On October 2, 2006 between 10:40 a.m. and 11:37 a.m., 21 residents were interviewed and stated their care needs were being met by the facility caregivers.

On October 4, 2006 at 9:15 a.m., the administrator stated she was not aware of a time when the needs of the residents were not being met by the caregivers at the facility.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 4, 2006.

Allegation #2: An identified resident is not given alternative meals when the facility's main meal does not honor the resident's religious diet preferences.

Findings: Based on interview it was determined the facility did offer alternative meals to the identified resident.

On October 3, 2006 at 10:00 a.m., the identified resident stated that although the facility would occasionally serve foods that he could not eat because of his religious diet preference they would offer him an alternative. He said frequently the alternative was something like soup which did not appeal to him and he would refuse it. Additionally, he stated he had foods in his room that he could eat if he needed to.

On October 4, 2006 at 9:40 a.m., the administrator stated that she always offered the resident, and any other resident alternatives to the main meal. She said the identified resident frequently refused the alternatives that were offered. She stated he told her he had food in his room that he could eat instead.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on October 4, 2006.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

RAE JEAN MCPHILLIPS, RN
Team Leader
Health Facility Surveyor
Residential Community Care Program

RM/slc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Cedar Crest Residential Care	1200 E 6th South	587-9013
Administrator	**City**	**ZIP Code**
Charlene Humphreys	Mountain Home	83647
Survey Team Leader	**Survey Type**	**Survey Date**
Rae Jean McPhillips	Standard/Complaint	10/4/06

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	210	The Facility did not offer activities to residents		
2	325	The Facility's nurse did not assess ~~all~~ residents every 90 days		
3	300.01	The Facility's nurse did not delegate assistance with medications and other nursing functions to unlicensed staff.		
4.	350.05	The Facility did not report inappropriate sexual behaviors to the appropriate agencies.		
5	211.11	The Facility did not document medications that were refused not given or not taken by the resident.		
6.	730.01q	~~Em~~ Criminal background history was done on all employees.		

Response Required Date	Signature of Facility Representative	Date Signed
11/1/06	Charlene Humphreys	